

Request for Application 07-65211

Sacramento Dental Geographic Managed Care Program

**California Department of Health Services
Office of Medi-Cal Procurement
1501 Capitol Ave., Suite 71-3041
Sacramento, CA 95814**

**P.O. Box 997413, MS-4200
Sacramento, CA 95899-7413**

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A. PURPOSE, BACKGROUND AND DESCRIPTION OF SERVICES

1. Purpose

The California Department of Health Services (CDHS), Medi-Cal Dental Services Branch (MDSB), invites Knox-Keene licensed dental Plans to apply for a contract with CDHS to provide dental services to Medi-Cal Beneficiaries residing in Sacramento County.

This Request for Application (RFA) is to identify Plans with the requisite qualifications and resources to provide dental services in Sacramento County. This is a non-competitive process.

The process described within this RFA will require dental Plans (Applicants) to complete an Application process. The Application shall require Applicants to submit information and documentation, detailed in the RFA, which CDHS will evaluate against published criteria. These criteria appear in RFA Section N, Evaluation. Evaluation shall consist of a pass/fail assessment. Applicants determined by CDHS to have passed all criteria shall be referred to the California Medical Assistance Commission (CMAC) for purposes of negotiating a contract. CDHS' determination that an Applicant is qualified for referral to CMAC for contract negotiation confers no rights or expectations that the Applicant will receive a contract.

Medi-Cal is California's Medicaid Program. CDHS is the single state agency with the authority and responsibility to administer the Medi-Cal program. This authority and responsibility includes administration of Medi-Cal dental services, including those services delivered through dental managed care contracts and the fee-for-service delivery system. In order to fulfill this responsibility, CDHS:

- 1) Contracts with Knox-Keene licensed dental plans operating in Sacramento County under the Geographic Managed Care (GMC) Pilot Project, pursuant to Welfare and Institutions Code (W&I) Section 14089 et seq. and California Code of Regulations (CCR), Title 22, Section 53500 et seq. and 53910 et seq.
- 2) Requires Applicants to be able to address all the services described in RFA Section A.3, Description of Services.

CDHS will refer to CMAC all Applicants that meet the qualifications and requirements set forth in this RFA. This RFA is open to all independent practices, associations, health insurance carriers, private foundations, university medical centers, non-for-profit clinics and other primary care providers organized and operated as managed care plans, for the

provision of managed healthcare plan services.

2. Background

In July 1965, amendments to the Social Security Act, Title XVIII established the Medicare program, and Title XIX established the state-option medical assistance program known as Medicaid. These programs were established to provide federal matching funds to states to implement a single, comprehensive medical care program.

State legislation implementing the Title XIX program was signed in November 1965. Medi-Cal, the California medical assistance Medicaid program, became effective in March 1966. Prior to the start of Medi-Cal, indigent Californians had been provided health care services through a variety of programs administered by the counties. With the advent of Medi-Cal, a wide range of health benefits was provided uniformly to those individuals throughout the State whose income and resources were insufficient to meet the costs of medical services without jeopardizing the person's or family's self-maintenance and security. Medi-Cal is funded primarily by federal and state monies. Generally, the federal government contributes 50% for Medi-Cal services costs related to virtually all beneficiaries currently covered by the program. With few exceptions, state government contributes the balance. The Medi-Cal program is administered by the State in cooperation with federal and county governments.

From its inception, Medi-Cal has experienced increasing program costs, primarily as a result of spiraling growth in the caseload, utilization of service, and hospital costs. A Medi-Cal Reform Plan (MRP) was enacted by statute in October 1971 (Chapter 577, Statutes of 1971) with the objective of developing an equitable statewide eligibility system, a uniform schedule of benefits for eligibles within a strong system of utilization and quality controls, and an improved system of health care delivery and health care financing for the program.

Modifications to the program are continually occurring because of federal and state legislation, departmental regulations, and other efforts to improve the program. Proposers should be aware that Contractor responsibility will include the planned and orderly implementation of the applicable provisions of all state and federal legislation and regulations whenever they may occur within the term of the contract.

The Sacramento County Dental GMC Program has been operational since April 1994. CDHS currently contracts with four Knox-Keene licensed dental Plans to provide dental services to approximately 160,000 Medi-Cal Beneficiaries. These contracts expire December 31, 2007.

3. Description of Services

- a. Services covered under the Dental GMC contract shall include all services described in Title 22, CCR, Chapter 3, Title 4, Sections 51059 and 51307.
- b. In order to maintain continuity of care, providing or arranging for covered services referenced in the aforementioned Sections shall be accomplished by:
 - 1) Ensuring that each member receives an initial dental assessment within 120 calendar days of enrollment with a dental Plan;
 - 2) Creating and maintaining an adequate system for tracking referrals and follow-up care;
 - 3) Monitoring the care provided to Plan Members, and coordinating all reasonable and necessary dental services both within and outside of the dental Plan's provider network;
 - 4) Developing and maintaining procedures that allow for follow-up on missed and/or broken appointments;
 - 5) Ensuring continuity of care from the primary care dentist to any dental care specialist, to include any referrals made for medical care with the member's medical plan.

4. Beneficiaries Plan Assignment

The following information provides Applicants with an understanding of how Beneficiaries are assigned to dental Plans:

- a. If a current Dental GMC Contractor is awarded a new contract, all Beneficiaries currently enrolled in that Plan shall continue to be members of that Plan, unless they elect to enroll in another contracted Plan.
- b. If a current Dental GMC Contractor is not awarded a new contract, Beneficiaries currently enrolled in that Plan will be given the opportunity to select another Plan. Beneficiaries who do not enroll in another plan within specified time frames shall be assigned to a Plan using the existing Default Algorithm.

The Default Algorithm provides that a newly eligible Medi-Cal Beneficiary is reviewed prior to being assigned to a Plan. CDHS considers whether the Beneficiary, or his/her family member, has a current or prior

relationship with a currently contracted Plan. If so, the Beneficiary will be assigned to that Plan. Beneficiaries and their family members will be assigned to the same Plan to ensure continuity of care. If no relationship/association with a Plan is discovered, the Beneficiary will be defaulted or assigned on a one-Beneficiary-to-one-Plan basis.

A Beneficiary who is currently enrolled in a Plan **not** awarded a new contract and who does **not** select another Plan, shall be reviewed and assigned to a Plan using the Default Algorithm described above.

Additionally, it should be noted that CDHS has no minimum number of Beneficiaries that a Plan must have and no maximum number of Beneficiaries a Plan may enroll in Sacramento County

B. TIME SCHEDULE

Below is the tentative time schedule for this Application:

Event	Date	Time (if applicable)
Request for Application Released	06/08/07	
Data Library Opens	06/08/07	
RFA Questions Due	06/22/07	4:00 p.m.
Mandatory Request for Inclusion on Mailing Due	06/22/07	4:00 p.m.
Mandatory Letter of Intent	06/22/07	4:00 p.m.
Application Due Date	06/22/07	4:00 p.m.
Applicant Status Notification Issued		

C. CONTRACT TERM

If a contract is awarded to the Applicant through successful negotiations with CMAC, the term of the contract will be no more than three (3) years.

CDHS' determination that an Applicant is qualified for referral to CMAC for contract negotiation confers no rights or expectations that the Applicant will receive a contract. The Applicant is hereby directed to not commence performance of any work identified in this RFA until a contract has been negotiated, all approvals have been obtained, and the contract executed. Should performance commence before a contract is issued, all approvals obtained, and the contract executed, said services may be considered voluntary and will not be reimbursed.

Any questions regarding a contract that may ultimately be developed as a result of this application should be directed to:

**Karen Thalhammer, Senior Negotiator
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814
(916) 324-2726
(916) 324-5597 Fax**

D. APPLICANT QUESTIONS

Please notify CDHS immediately if you need clarification about the services sought or have questions about the RFA instructions or requirements. Put your question in writing and transmit it to CDHS as instructed below. At its discretion, CDHS reserves the right to contact an inquirer to seek clarification of any question received.

Applicants that fail to report a known or suspected problem with the RFA or fail to seek clarification and/or correction of the RFA submit an Application at their own risk.

1. What to include in a question:
 - a. Applicant's name, Applicant representative's name, mailing address, area code and telephone number, email address and fax number.
 - b. A description of the subject or issue in question or discrepancy found.
 - c. Application section, page number or other information useful in identifying a specific problem or issue in question.
 - d. Remedy sought, if any.

2. Question Deadline

CDHS will accept written or faxed questions received by 4:00 p.m. (PDT) on June 22, 2007. At its discretion, CDHS may contact an inquirer to seek clarification of any question received.

Exception: CDHS' Office of Medi-Cal Procurement (OMCP) will accept questions regarding the reporting of RFA errors or irregularities issues up to the Application submission deadline.

3. How to Submit Questions

Submit inquiries using one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
RFA 07-65211 Questions: Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	RFA 07-65211 Questions: Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814
Fax:	
RFA 07-65211 Questions: Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	
Email: OMCP RFP6@dhs.ca.gov	

Applicants submitting questions via fax are responsible for confirming the receipt of all faxed materials by the question deadline by calling OMCP (916) 552-8006.

Applicant Warning on Mail Processing

CDHS' internal processing of U.S. mail may add up to 48 hours to the receipt time. For time-sensitive correspondence or documents sent to CDHS, Applicants should consider using certified, registered or express mail. Applicants are advised to **request a return receipt confirming the delivery date and the time of delivery.** Applicants choosing to hand-deliver questions or Applications should allow sufficient time to locate parking and sign in at the security desk.

For driving and parking instructions, see Appendix 1.

4. Verbal Questions

Because verbal questions are easily misinterpreted, Applicants are highly encouraged to submit all questions in writing. CDHS reserves the right not to accept or respond to verbal questions. Verbal remarks provided in response to verbal questions are of no force and effect and not binding on CDHS unless later confirmed in writing.

No inference should be drawn from any question to which CDHS does not respond in writing or otherwise.

E. DATA LIBRARY

A Data Library for the sole use of Applicants will be established on June 8, 2007. The Data Library will be accessible by appointment on State working days Monday through Friday from 8:00 a.m. to 12:00 p.m. (noon), and 1:00 p.m. to 4:00 p.m. (PDT). Access to the Data Library is restricted to authorized Applicants and/or their authorized representatives who have established an advance appointment through the process described below. Applicants must have a complete, signed set of Authorization Documents on file with OMCP. The same Applicant official shall sign all Authorization Documents.

1. Authorization Documents

Documents required to be on file for access to the Data Library shall include:

- a. Data Library Confidentiality Agreement; and
- b. List of Authorized Personnel

2. Location

CDHS will maintain the Data Library at the following location:

**Office of Medi-Cal Procurement
1501 Capitol Ave, Suite 71-3041
Sacramento, CA 95814**

For driving and parking instructions, see Appendix 1.

3. Appointments (Required for Access)

Applicants seeking appointments to access the Data Library must submit their request in writing. The following information must be included in an Applicant's written request for an appointment:

- a. Name
- b. Title
- c. Applicant
- d. Telephone number
- e. Fax Number
- f. Email address, if applicable
- g. Desired date of visit
- h. Desired time of visit

OMCP shall promptly respond to requests for appointments and schedule them in a timely fashion.

Send your written request to OMCP via one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814
Fax:	
RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	
Email: OMCPRFP6@dhs.ca.gov	

4. Data Library Contents

The Data Library contains various documentation and information that Applicants may find beneficial in the preparation of their RFA responses. Data Library materials may be periodically updated and additional documents may be added. Applicants that have requested access to the Data Library will be notified of the additions and/or changes in writing.

5. Obtaining Copies of Library Materials

Applicants that wish to obtain reproduced copies of Data Library materials may do so by contacting Lenatte Blouin or Sharon Turk at (916) 552-8006. Applicants are requested to provide their own copying services.

The Data Library is also available electronically at www.dhs.ca.gov/omcp. The Department strongly encourages Applicants to use this medium to obtain copies of Data Library documents. Please contact Lenatte Blouin or Sharon Turk at (916) 552-8006 for details on obtaining a CD-R copy of the Data Library materials.

F. REASONABLE ACCOMMODATIONS

For individuals with disabilities, CDHS will provide services such as conversion of RFA, questions/answers, RFA Addenda, applicable library materials, or other Administrative Notices into Braille, large print, audio cassette or computer disk. To request such services or copies in an alternate format, please call the number below to arrange for reasonable accommodations, in sufficient time to comply with all timelines:

Lenatte Blouin/Sharon Turk
Office of Medi-Cal Procurement
(916) 552-8006

G. “MANDATORY” LETTER OF INTENT

1. General Information

Prospective Applicants are requested to indicate either their intention to submit an Application or the reason(s) for not submitting an Application. Failure to submit a Letter of Intent will affect the acceptance of any Application. The Mandatory Letter of Intent is non-binding and prospective Applicants are not required to submit an Application merely because a Letter of Intent is submitted. **Use the Mandatory Letter of Intent (Attachment 5) for this purpose.**

2. Submitting a Letter of Intent

The Mandatory Letter of Intent must be received by **4:00 p.m. on June 22, 2007**. Submit the Mandatory Letter of Intent using one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
RFA 07-65211 Sacramento Dental GMC Lenatte Blouin or Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	RFA 07-65211 Sacramento Dental GMC Lenatte Blouin or Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814
Fax:	
RFA 07-65211 Sacramento Dental GMC Lenatte Blouin or Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	

3. Mandatory Request for Inclusion on Mailing List

CDHS recognizes that not all entities/persons who received this RFA are interested in continuing to receive updates. In addition, printing and mailing updates to all RFA recipients is costly to CDHS. Therefore, CDHS will continue to provide automatic updates about this RFA only to prospective Applicants who have provided a mandatory Request for Inclusion on Mailing List form (Attachment 4). Regardless of delivery method, this form must be received by OMCP by 4:00 p.m. (PDT) on June 22, 2007.

It is incumbent upon any Applicant who has not submitted the mandatory Request for Inclusion on Mailing List form, but intends to submit an Application, to monitor the website at www.dhs.ca.gov/omcp for any administrative bulletins, notifications regarding the RFA process, or addenda to the RFA.

Prospective Applicants may also call (916) 552-8006 to request any administrative bulletins, notifications, and/or RFA addenda.

Submit the mandatory Request for Inclusion on Mailing List form using one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
RFA 07-65211 Mailing List Sacramento Dental GMC Lenatte Blouin or Sharon Turk Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	RFA 07-65211 Mailing List Sacramento Dental GMC Lenatte Blouin or Sharon Turk Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814
Fax:	
RFA 07-65211 Mailing List Sacramento Dental GMC Lenatte Blouin or Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	

H. QUALIFICATION REQUIREMENTS & REQUIRED DOCUMENTATION

Failure to meet or provide the following requirements and information by the RFA submission deadline will be grounds for CDHS to deem an Applicant non-responsive. Evaluators may choose not to review an Application that fails to

meet these requirements. In submitting an Application, each Applicant must, at a minimum, meet and/or provide the following:

1. Knox-Keene Licensure

Applicant shall provide a copy of their unrestricted Knox-Keene license showing authority to operate in Sacramento County as a dental Plan.

2. Current/Projected Dental Provider Network in Sacramento County

- a. The Applicant must currently have, or be able to demonstrate possession of prior to contract execution, a dental provider network in Sacramento County.
- b. Provide the number of the Plan's currently contracted or anticipated primary care dentists located within Sacramento County who do/will provide services to Medi-Cal Beneficiaries. Include the ratio of primary care dentists and dental specialists to the prepaid patient population. Prepaid patient population is defined as the number of Medi-Cal Beneficiaries residing in Sacramento County who currently are, or are anticipated to be, members of the Applicant's GMC Plan.
- c. Include a copy of the Letter of Intent signed by any primary care dentist or dental specialist who is not currently contracted by the Plan to provide dental services to Medi-Cal Beneficiaries in Sacramento County, but who has stated his/her willingness and ability to do so if the Applicant is awarded a contract. .

3. Financial Stability

- a. The Applicant shall be in good financial standing with the Department of Managed Health Care (DMHC). The Applicant shall submit a letter from DMHC demonstrating that the Applicant is financially sound and in good standing with the DMHC.
- b. Submit a copy of the Applicant's audited financial statements, as prepared by a certified public accountant, for the most recently completed fiscal year.
- c. CDHS recognizes for audited statements to meet the requirements of Generally Accepted Accounting Principles (GAAP) they may not have been prepared in a manner that follows the definition of affiliates as defined by CCR § 53102. To address this issue, CDHS will recognize audited statements prepared in accordance with GAAP as meeting the combined presentation of requirement for affiliates. CCR, Title 22, § 53102 defines an affiliate as *an*

organization or person that, directly or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with, a Plan and that provides services to or received services from a Plan.

d. The submitted statements should include:

- 1) Annual Income Statement(s).
- 2) Annual Balance Sheet.
- 3) A Statement of Cash Flow or Uses of Cash Statement.
- 4) Retain Earning Statement or Statement of Equity.
- 5) Any accompanying notes or statements and a copy of the opinion letter for the annual audit reports provided.
- 6) A copy of any quarterly reports, audited or unaudited, prepared after the last annual report.
- 7) If dependent on an affiliate to provide service under this Application, include the budgets of those affiliates in the financial disclosures provided.
- 8) A Projected Tangible Net Equity calculation.
- 9) A detailed cash flow budget, including all written assumptions, estimates and projections, demonstrating the availability and sources of funds to meet the obligations under the contract, for the prospective contract period. If Applicant relies upon affiliates to provide services under the contract, supporting budgets for such affiliates must be provided (Number 5 A of CCR § 53500).
- 10) If any material change in the Applicant's financial position has occurred between the creation of the financial statements and submission of this Application, those changes must be identified and explained in detail.

4. Chief Financial Officer Certification

A statement, signed by the Applicant's Chief Financial Officer, certifying that the financial statements submitted with the Application are accurate, complete with no material errors or omissions, and representative of the financial position of the Applicant, as of the submission date.

5. Beneficiary Non-Discrimination Certification

Applicants must certify that they are willing and able to enroll members regardless of their race, creed, color, religion, age, sex, national origin, sexual orientation, marital status or ancestry; and without reference to pre-existing medical conditions other than those specifically excluded from coverage under the contract. Certification can be achieved by completing Attachment 8 and being signed by the appropriate binding officer or agent (Number 11 of CCR § 53500).

6. Applicant must agree to enter into an agreement with CDHS upon being notified of acceptance of application. The agreement is to reimburse CDHS for the costs of administrative and regulatory contract oversight of the Medi-Cal Dental Services contract.

J. RFA FORMAT AND CONTENT REQUIREMENTS

1. General Instructions

- a. Before submitting an Application, Applicants should seek timely written clarification of any requirements or instructions they believe to be vague, unclear or that they do not fully understand.
- b. In preparing the RFA response, all narrative portions should be straightforward, detailed and precise. CDHS will determine the responsiveness of an Application by its quality, not its volume, packaging or colored displays.
- c. Arrange for the timely delivery of the Application to the address specified in this RFA. Do not wait until shortly before the deadline to submit an Application.

2. Format Requirements

- a. The Application shall address all items detailed in the RFA and present a complete description of how the Applicant shall meet RFA requirements.
- b. Applicants must:

- 1) use one-inch margins at the top, bottom, and both sides.
 - 2) use a font size of not less than 11 points.
 - 3) print pages single-sided on white bond paper.
 - 4) consecutively number the pages. Documents contained in the Forms and Appendix Sections do not require pagination.
- c. Submit one (1) original, five (5) copies, and one (1) CD-ROM of the Application. Label the original hard copy "Original" and number each copy. Label the CD-ROM "RFA 07-65211, Sacramento County Dental Geographic Managed Care", the date, and your Plan's name.
- d. Separately bind the original and each hard copy.
- e. Send all application materials under sealed cover. Label the box(es) or package(s) with the same information as described in 2.c., above.

K. CONTENT REQUIREMENTS

This section specifies the order and content of each Application. Assemble the materials in the following order:

1. Application Cover Page

A person authorized to bind the Applicant must complete and sign the Application Cover Page (Attachment 1). If the Applicant is a corporation, a person authorized by the Board of Directors to sign on behalf of the Board must sign the Application Cover Page.

2. Table of Contents

Properly identify each section and the contents therein.

3. History and Background Summary

Include a brief history of the dental Plan, including:

- a. The date the Plan was established, and its business or organizational structure.
- b. A description of the Applicant's goals that are relevant, closely related, and which compliment this project.

- c. Demonstration that the Applicant has a history of committing resources, expertise, and energy to perform this type of work.

4. Required Documentation

Documentation detailed below will be reviewed to confirm that the required materials are present and conform to the RFA requirements.

- a. The Applicant shall provide a detailed narrative of how the Plan will provide all reasonable and necessary covered dental services for eligible Medi-Cal Beneficiaries as set forth in Title 22, CCR, Chapter 3, Article 1.3, § 51003; Title 22, CCR, Chapter 3, Article 2, § 51059, and Title 22, CCR, Chapter 3, Article 4, § 51307.
 - 1) For purposes of this Application, outpatient and inpatient dental services which are “Reasonable and Necessary” for the prevention, diagnosis, and treatment of dental disease, injury or defect are covered to the extent specified in Title 22, CCR, Chapter 3, Article 4, § 51307.
 - 2) The Applicant shall comply with and adhere to all State and Federal laws, regulations, policies, and guidelines as required by the Medi-Cal Program.
- b. The Applicant shall provide a detailed narrative of the system or process used to define the standard of care provided and a review of those standards of care on a continuous basis. The discussion must include the method and standards used to evaluate the quality of care provided.
- c. The Applicant shall provide a detailed narrative of the system or process used to review the performance of dental personnel.
- d. The Applicant shall provide a detailed narrative on the system in place to review the effectiveness of controls on utilization and cost of services.
- e. The Applicant shall provide a copy of its internal quality assurance program or Quality Improvement Program (QIP). The information provided shall, at a minimum, address each of the following:

Requirement of an Internal Quality Assurance Program

- 1) Is consistent with the utilization control requirement of the Code of Federal Regulations (CFR) Title 42, § 456.6;

- 2) Provides for a review by appropriate health professionals of the process followed in providing dental services;
 - 3) Provides for systematic data collection of provider performance and patient results;
 - 4) Provides for interpretation of this data to the providing dentists;
 - 5) Provides for making needed changes.
- f. The Applicant shall describe how it will provide emergency services. An explanation of how the Applicant will provide for prompt reimbursement of non-plan providers for emergency services rendered to members, shall be included.
 - g. The Applicant shall describe its process for handling and recording dental records.
 - h. The Applicant shall attest to its willingness and ability to provide dental services to Medi-Cal Beneficiaries residing in Sacramento County by completing Attachment 9 and including it in the Forms Section.
 - i. The Applicant shall provide a description of proposed marketing efforts, with realistic enrollment and marketing cost projections, for Medi-Cal Beneficiaries in Sacramento County.
 - j. The Applicant shall provide copies of all proposed or existing subcontracts related to securing health care services, administrative and management services or any other services necessary to fulfill its contractual obligations.
 - k. The Applicant shall provide a description of the proposed or existing procedures by which grievances submitted by Beneficiaries are promptly processed and resolved.
5. Organizational Section

The Applicant shall provide an organization chart. The chart shall identify, by name and title, all principals, policymakers, executive officers, dental directors and administrators. For persons identified in the organization chart, the Applicant shall provide, at a minimum, the following information either within the chart, as attached résumés or other appropriate presentation:

- 1) Full name.

- 2) Business address.
- 3) Internal Revenue Service employer number, when applicable.
- 4) License number, dental specialty and Medi-Cal provider number, when applicable.

6. Facilities and Resources Section

The Applicant shall describe the following as it relates to its capacity to perform reasonable and necessary dental services:

- a) Current office facilities that will be utilized in the execution of this contract. Include the number of staff available to work on the contract. Provide the full address of any location where any substantial portion of the work will be performed.
- b) Clearly indicate if any of the work, including storing, processing or maintaining dental records of Beneficiaries is to be performed outside of the jurisdiction of the United States.
- c) Location and description of all service sites and dental offices, with information about the services available at each location.
- d) Current support services and office equipment capabilities immediately available and/or accessible for use in carrying out the work described in this RFA and referenced statute. Include, at a minimum:
 - 1) A description of the range and/or type of support services available and number of staff;
 - 2) Teleconferencing or telecommunications capabilities;
 - 3). Computer hardware and system capabilities (i.e., number, type, size, age, capacity and speed of personal computers or work stations and servers; Local Area Network capabilities; Wide Area Network capabilities; data transfer capabilities (disk or tape); data storage capacity, video/graphics capabilities, etc.);
- e) Software applications in use (word processing applications, spreadsheet applications, data base applications, unique or other specialized software applications, etc.);

At a minimum, Applicants shall have or make arrangements to acquire Microsoft Word and Excel (2000 or a newer versions of each), to ensure adequate performance in the provision of

reasonable and necessary dental services and compatibility with the MDSB.

L. FORMS SECTION

Complete, sign and include the forms/attachments listed below. When completing the attachments, follow the instructions in this section and any instructions appearing on the attachment. After completing and signing the applicable attachments, assemble them in the order shown below.

Attachment and/or Documentation	Instructions
1. Application Cover Page	Complete the form, including the signature of the Authorized Representative
2. Required Attachment/ Certification Checklist	<p>Check each item with “Yes”, “No” or “N/A”, as applicable, and sign the form. If necessary, explain your responses.</p> <p>If an Applicant marks “Yes”, “No” or “N/A” and makes any notation on the checklist and/or attaches an explanation to the checklist to clarify their choice, CDHS considers this a “qualified response”. Any “qualified response”, determined by CDHS to be unsatisfactory or insufficient to meet a requirement, may cause an Application to be deemed non-responsive.</p>
3. Applicant Information Sheet	Completion of the form is self-explanatory.
4. Mandatory Request for Inclusion on Mailing List	Completion of the form is self-explanatory.
5. Mandatory Letter of Intent	Completion of the form is self-explanatory.
6. Current /Proposed Dental Provider Network	Completion of the form is self-explanatory.
7. Payee Data Record	Complete and return this form, only if you have not previously entered into a contract with CDHS. If

Attachment and/or Documentation	Instructions
	uncertain, complete and return the form.
8. Beneficiary Non-Discrimination Certification	Completion of the form is self-explanatory.
9. Attestation	Completion of the form is self-explanatory.

M. APPLICATION SUBMISSION

1. Mail or arrange for hand delivery of your Application to CDHS, OMCP. Applications may not be transmitted electronically by fax or email.
2. To be considered timely, OMCP must receive the Application, regardless of postmark or method of delivery, by **4:00 p.m. (PDT) on July 23, 2007**. Late Applications will not be reviewed or scored and will be deemed non-responsive.
3. Submit Application using one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814

4. Proof of Timely Receipt

CDHS staff will log and attach a date/time stamped slip or bid receipt to each Application received. If an Application is hand delivered, CDHS staff will provide a receipt to the hand carrier upon request.

5. Application Cost

Applicants are responsible for all costs of developing and submitting an Application. These costs cannot be charged to CDHS.

N. EVALUATION

Evaluation will consist of multiple stages as detailed below. The evaluation process will be used to review and/or score Applications. CDHS will reject any Application that is found to be non-responsive at any stage of evaluation. An evaluation committee will be used for all stages during the evaluation process. The evaluation committee is comprised of four groups:

- The **Preliminary Review Committee (PRC)** consists of team leads from the OMCP and the MDSB and conducts Stage 1 review.
- The **Evaluation Scoring Committee (ESC)** consists of the MDSB staff and CDHS staff working in other areas of the Medi-Cal Program. The ESC is responsible for the review of the Applications.
- The **Rating Review Committee (RRC)** consists of OMCP management staff and members of the PRC. The RRC will interact with the ESC throughout the evaluation process.
- The **Executive Review Committee (ERC)** consists of CDHS management officials. The ERC may, at the members' discretion, review evaluation processes and recommended scores for each Application throughout this evaluation process. This review is to assure all appropriate procedures and processes have been followed. Additionally, the ERC may seek independent review or advice from individuals within CDHS or elsewhere regarding evaluation policy matters, Application deficiencies, and acceptability.

1. Stage 1 – Reviewing Required Attachment/Certification Checklist, Attachment 2 (Pass/Fail)

- a. Shortly after the Application submission deadline, the PRC will convene to review each Application for timeliness, completeness and initial responsiveness to the RFA requirements. This is a pass/fail evaluation.
- b. In this review stage, the PRC will compare the contents of each Application to the claims made by the Applicant on the Required Attachment/Certification Checklist, Attachment 2, to determine if the Applicant's claims are accurate.

If deemed necessary, the PRC may collect additional documentation (i.e., missing forms, missing data from the Application attachments, missing signatures, etc.) from an Applicant to confirm the claims made on the Required Attachment/Certification Checklist, to ensure that the Application is initially responsive to the RFA requirements.

- c. If an Applicant's claims on the Required Attachment/Certification Checklist cannot be proven or substantiated, the Application may, at CDHS' sole discretion, be deemed non-responsive and rejected from further consideration.

2. Stage 2 – Scoring the Application (Pass/Fail)

- a. Applications that appear to meet the basic format requirements, initial qualification requirements and contain the required documentation as evidenced by passing the Stage 1 review will be submitted to the ESC.
- b. The ESC will individually and/or as a team evaluate Applications, determining the adequacy, thoroughness, and the degree to which they comply with the RFA requirements.
- c. Because this is not a competitive bid process, the ESC will use a pass/fail system to evaluate each Application. **Applicants must pass each question to be referred to CMAC for contract negotiation.**

The definitions of pass/fail appear in the chart below:

Points	Interpretation	General basis for assignment
Pass	Adequate	RFA response (i.e., content and/or explanation offered) is at a minimum, adequate or meets CDHS' needs/requirements or expectations. The omission(s), flaw(s), or defect(s), if any, are inconsequential and acceptable.
Fail	Inadequate	RFA response (i.e., content and/or explanation offered) does not meet CDHS' needs/requirements or expectations. The omission(s), flaw(s), or defect(s) are significant and unacceptable.

Evaluation Questions		Pass	Fail
1.	Has the Applicant shown that it has/will have by contract execution date programs in place to provide reasonable and necessary dental services for eligible Medi-Cal Beneficiaries as set forth in Title 22, CCR, Chapter 3, Article 2, § 51307?		
2.	Does the Applicant's quality assurance program or Quality Improvement Program (QIP) demonstrate its ability to provide professional oversight consistent with CFR, Title 42, § 456.6?		
3.	Has the Applicant provided a description of the system or process used to set standards for acceptable dental care in accordance with Title 22, CCR, § 53500? Does the Applicant's system or process include provisions for evaluating the quality of care provided?		
4.	Has the Applicant provided a description of the proposed or existing procedures by which grievances submitted by members are to be promptly processed and resolved?		

O. APPLICATION REQUIREMENTS AND INFORMATION

1. Non-Responsive Applications

In addition to any condition previously indicated in this RFA, the following occurrence **may** cause CDHS to deem an Application non-responsive.

- a. Failure of an Applicant to:
 - 1) Meet the Application format/content or submission requirements including, but not limited to, the sealing, labeling, packaging and/or timely and proper delivery of an Application.
 - 2) Pass the Required Attachment/Certification Checklist review (i.e., by not marking “Yes” to applicable items or by not appropriately justifying, to CDHS’ satisfaction, all “N/A” or “No” designations).
- b. The submission of an Application that is conditional, materially incomplete or contains material defects, alterations or irregularities of any kind.
- c. The submission supplies false, inaccurate or misleading information or falsely certifies compliance on any RFA attachment.
- d. If CDHS discovers, at any stage of the Application or negotiation process that the Applicant is unwilling or unable to comply with the contract terms, conditions and exhibits cited in this RFA or that resulting contract.
- e. Any other irregularities that occur in an Application that are not specifically addressed herein (i.e., the Applicant places any conditions on performance of the work detailed in this RFA and referenced statute, submits a counter offer to the RFA, etc.).

2. RFA Modifications After Submission

All Applications are to be complete when submitted. However, an entire Application may be withdrawn and the Applicant may resubmit a new Application, if resubmission occurs before the expiration of the submission deadline.

3. Withdrawal and/or Resubmission of Applications

- a. Withdrawal Deadlines

An Applicant may withdraw an Application at any time before the Application submission deadline.

With the consent of CDHS, an Application may be withdrawn after the Application submission deadline. An Application withdrawn after the submission deadline may not be resubmitted or replaced by a newly submitted Application.

b. Submitting a Withdrawal Request

- 1) Submit a written withdrawal request, signed by an authorized representative of the Applicant.
- 2) Label and submit the withdrawal request using one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
Withdrawal RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	Withdrawal RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814
Fax:	
Withdrawal RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	

- 3) Applicants must call (916) 552-8006 to confirm receipt of a faxed withdrawal request. Follow-up the faxed request by mailing or delivering the signed original withdrawal request within 24 hours after submitting a faxed request.

An originally signed withdrawal request is generally required before CDHS will return an Application to an applicant. CDHS may grant an exception if the Applicant informs CDHS that a new or replacement Application will immediately follow the withdrawal.

4. Resubmitting an Application

After withdrawing an Application, Applicants may resubmit a new Application according to the Application submission instructions. The

replacement Application must be received at the stated place of delivery by the Application due date and time.

5. Notification and Appeals

Application Status Notification

- a) Following the conclusion of evaluation, OMCP will notify each Applicant of its status. Applicants that passed every evaluation question will be referred to CMAC and so noticed. Applicants that failed one or more evaluation questions will be notified of the deficiency(ies) that resulted in CDHS not referring their Application to CMAC. Notifications shall be transmitted via fax.
- b) Any failing Applicant may appeal to CDHS by filing an appeal within fifteen (15) working days from the date CDHS faxed the failure notification, to the person and address noted below. The appeal must provide a complete and detailed narrative, including all supporting documentation that addresses the basis for the failure. A written resolution of the appeal will be provided within seven (7) working days from date appeal is received. As this is a non-competitive bid, no appeal will stop or delay the successful Applicants from negotiating with CMAC regarding their individual contracts.
- c) Applicants shall submit appeals to:

U.S. Mail:	Hand Delivery or Overnight Express/Courier:
Appeals RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement P.O. Box 997413 / MS4200 Sacramento, CA 95899-7413	Appeals RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento, CA 95814

- d) CDHS will post the names of all Applicants referred to CMAC on the OMCP website at www.dhs.ca.gov/omcp.

6. Disposition of Applications

- a. All materials submitted in response to this RFA will become the property of CDHS and, as such, are subject to the Public Records Act (Government Code, § 6250, et seq.). CDHS will disregard any language purporting to render all or portions of any Application confidential.

- b. Applications are public records upon the issuance of Application Status Notification to all Applicants following evaluation.
 - c. CDHS may return a failing Application to an Applicant at its request and expense six (6) months after CDHS concludes the Application evaluation process.
7. Inspecting or Obtaining Copies of Applications
- a. Who Can Inspect or Copy Application Materials
- Any person or member of the public can inspect or obtain copies of any RFA and Application materials.
- b. What Can Be Inspected/Copied and When
- On or after CDHS issues the Application Status Notifications, Applications, Mandatory Letters of Intent, checklists and/or scoring/evaluation sheets become public records. These records shall be available for review, inspection and copying during normal business hours.
- c. Inspecting or Obtaining Copies of Application Materials
- Persons wishing to view or inspect any Application or evaluation-related materials must identify the items they wish to inspect and must make an inspection appointment by contacting **Lenatte Blouin or Sharon Turk at (916) 552-8006**.
- Persons wishing to obtain copies of Application materials may visit CDHS or mail a written request to the CDHS office identified below. The requestor must identify the items they wish to have copied. Materials will not be released from State premises for the purposes of making copies.
- Unless waived by CDHS, a check covering copying and/or mailing costs must accompany the request. Copying costs, when applicable, are charged at a rate of ten cents per page. CDHS will fulfill all copy requests as promptly as possible. Submit copy requests as follows:
- Request for Copies – Application 07-65211
Sacramento Dental GMC
Lenatte Blouin or Sharon Turk
Department of Health Services
Office of Medi-Cal Procurement
1501 Capitol Ave, Suite 71-3041**

**P.O. Box 997413, MS4200
Sacramento, CA 95899-7413**

8. Verification of Applicant Information

By submitting an Application, Applicants agree to authorize CDHS to:

- a. Check any reference identified by an Applicant or other resources known by the State to confirm the Applicant's business integrity and history of providing effective, efficient and timely services.
- b. Verify any and all claims made by the Applicant including, but not limited to verification of provider agreements, licensing and the possession of any other qualification requirements.

9. CDHS Rights

In addition to the rights discussed elsewhere in this RFA, CDHS reserves the following rights:

a. RFA Corrections

- 1) CDHS reserves the right to do any of the following up to the Application submission deadline:
 - A) Modify any date or deadline appearing in this RFA or the RFA Time Schedule.
 - B) Issue clarification notices, addenda, alternate RFA instructions, forms, etc.
 - C) Waive any RFA requirement or instruction for all Applicants if CDHS determines that the requirement or instruction was unnecessary, erroneous or unreasonable.
 - D) Allow Applicants to submit questions about any RFA change, correction or addenda. Specific instructions about submitting questions and deadlines will appear in the cover letter accompanying the document detailing the RFA change.
- 2) If this RFA is clarified, corrected, or modified CDHS will mail, fax or email a clarification notice and/or Application addenda to all Applicants who submitted the Mandatory Request for Inclusion on the Mailing List on time. This information may

also be obtained by accessing the OMCP website at www.dhs.ca.gov/omcp.

- 3) If CDHS decides, just before or on the Application due date, to extend the submission deadline, CDHS may choose to notify potential Applicants of the extension by fax or by telephone.

b. Collecting Information from Applicants

- 1) If deemed necessary, CDHS may request an Applicant to submit additional documentation during or after the Application review and evaluation process. CDHS will advise the Applicants orally, by fax or in writing, of the documentation that is required and the time line for submitting the documentation. CDHS will follow-up oral instructions in writing by fax or mail. Failure to submit the required documentation by the date and time indicated may cause CDHS to deem an Application non-responsive.
- 2) CDHS, at its sole discretion, reserves the right to collect, by mail, fax or other methods the following omitted documentation and/or additional information:
 - A) Signed copies of any form submitted without a signature.
 - B) Data or documentation omitted from any submitted Application attachment/form.
 - C) Information/material needed to clarify or confirm certifications or claims made by an applicant.
 - D) Information/material needed to correct or remedy an immaterial defect in an Application.
- 3) The collection of Applicant documentation may cause CDHS to extend the date for issuing Application Status Notification to all Applicants. If CDHS changes the issuance date, CDHS will advise the Applicants, orally or in writing, of the alternate date.

c. Immaterial Application Defects

- 1) CDHS may waive any immaterial defect in any application and allow the Applicant to remedy those defects. CDHS reserves the right to use its best judgment to determine what constitutes an immaterial deviation or defect.
- 2) CDHS' waiver of an immaterial defect in an application shall in no way modify this Application or excuse an Applicant from full compliance with all application requirements.

d. Correction of Clerical or Mathematical Errors

CDHS reserves the right, at its sole discretion, to overlook, correct or require an applicant to remedy any obvious clerical or mathematical errors occurring in the narrative portion of an application.

e. Right to Remedy Error

CDHS reserves the right to remedy errors caused by:

- 1) CDHS office equipment malfunctions or negligence by agency staff,
- 2) Natural disasters (i.e., floods, fires, earthquakes, etc.),
- 3) Any other catastrophic event beyond the control of CDHS.

f. No Contract Award or Application Cancellation

The issuance of this RFA does not constitute a commitment by CDHS to refer an Applicant to CMAC for contract negotiations. CDHS reserves the right to reject any or all Applications and to cancel this RFA if it is in the best interests of the State to do so.

g. Staffing Changes after Contract Award

CDHS reserves the right to approve or disapprove changes in Key Personnel that occur after application approval.

APPLICANT COVER PAGE

Name of Applicant's Firm *(Legal name as it would appear on a contract)*

Mailing Address *(Street address, P.O. Box, City, State, Zip Code)*

Person authorized to act as the contact for this firm in matters regarding this application:Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

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Person authorized to obligate this firm in matters regarding this application or the resulting contract:Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

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(CORPORATIONS) Name/Title of person authorized by the Board of Directors to sign this bid on behalf of the Board:Printed Name *(First, Last)*:

Title:

Signature of Applicant or Authorized Representative

Date:

REQUIRED ATTACHMENT CERTIFICATION CHECKLIST

Qualification Requirements. I certify that the Applicant meets the following requirements and has provided the appropriate documentation when required:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant is financially stable and solvent and has adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided a copy of current, unrestricted Knox-Keene License as a dental plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has included a Department of Managed Health Care (DMHC) statement showing it is in good standing with the DMHC as a dental plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Applicant has included the most recent audited annual report including the Income Statement, Balance Sheet, Statement of Cash Flow, all accompanying notes and the opinion letter for the annual report.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has included a detailed cash flow budget, including all written assumptions, estimates and projections, demonstrating the availability and sources of funds needed to meet the obligations as a prospective contractor, for the prospective contract period.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Applicant has included all affiliate budgets, where it relies on the affiliate to provide services allowing it to operate in Sacramento County.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has included a calculation of projected TNE, as provided to DMHC.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	The Chief Financial Officer has provided a statement affirming the financial statements provided as a true representation of the current financial condition of the Applicant.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided a description of its administrative structure.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided information on the functions and responsibilities of all principals, policymakers, executive officers, dental directors and administrators including: name, business address, IRS employer number and any applicable dental specialty, license numbers and Medi-Cal provider number.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Applicant has provided a list of all subcontracts with Applicant and all affiliates.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided the location and description of all dental offices, and other facilities related to this Application.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Required Attachment Certification Checklist

Qualification Requirements. I certify that the Applicant meets the following requirements and has provided the appropriate documentation when required:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided a description of proposed marketing efforts with realistic enrollment and marketing cost projections for Medi-Cal Beneficiaries in Sacramento County.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided a description of the procedures for providing emergency dental care. Applicant has also included a description of the procedures for providing prompt reimbursement of non-plan providers for emergency services rendered to members.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has provided a description of its process for the handling and recording of dental records.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Applicant has provided copies of all proposed or existing subcontracts to secure dental services, administrative and management services, including any other services necessary to meet the requirements of this RFA, except as allowed by statute.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Required Attachment / Certification Checklist Form Section with the Following Attachments / Forms:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 1, Application Cover Page	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 2, Required Attachment / Certification Checklist	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 3, Applicant Information Sheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 4, Request for Inclusion on Mailing List	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 5, Mandatory Letter of Intent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 6, Applicant has provided the Current/Proposed Dental Provider Network,.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 7, Payee Data Record. [Check "N/A" if you have had a prior contract with CDHS.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attachment 8, Applicant has completed Beneficiary Non-Discrimination Certification.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 9, Attestation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Firm:		
Printed Name/Title:		
Signature	Date:	

RFA 07-65211

APPLICANT INFORMATION SHEET

A signature affixed hereon and dated, certifies compliance with all application requirements. Our signature authorizes the State to verify the claims made on this certification.

Name of Firm:		CA Corp. No. (If applicable)		Federal ID Number
Name of Principal (If not an individual):	Title:		Telephone Number	Fax Number
Street Address / P.O. Box		City	State	Zip Code

Type of Business Organization / Ownership (Check all that apply)

Ownership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Joint venture <input type="checkbox"/> Association	Corporation <input type="checkbox"/> Nonprofit <input type="checkbox"/> For Profit <input type="checkbox"/> Private <input type="checkbox"/> Public	Governmental <input type="checkbox"/> City/County, California State Agency, Federal Agency, State (other than California) <input type="checkbox"/> Other:	Other Type of Entity <input type="checkbox"/> Public or Municipal Corporation, School or Water District, California State College, University of California, Joint Powers Agency <input type="checkbox"/> Auxiliary College Foundation <input type="checkbox"/> Other:
--	--	--	--

California Certified Small Business Status ☐ N/A ☐ Microbusiness ☐ Small business

☐ Certified By DGS Certification No: _____ Expiration Date: _____

If certified, attach a copy of certification letter. | If an application is pending, date submitted to DGS: _____

Small Business Type (If applicable) ☐ N/A ☐ Services ☐ Non-Manufacturer ☐ Manufacturer

☐ Contractor (Construction Type): _____ ☐ Contractor's License Type: _____

Veteran Status of Business Owner ☐ N/A

☐ Disabled Veteran Certified by DGS Certification No. _____ Expiration Date: _____

If certified, attach a copy of certification letter. | If an application is pending, date submitted to DGS: _____

Disadvantaged Business Enterprise Status: ☐ N/A ☐ Approved by the Cal Trans, Office of Civil Rights.

Certification number issued by Cal Trans: _____ Expiration Date: _____

Race/Ethnicity of Business Owner ☐ N/A ☐ Black ☐ Hispanic ☐ Non-Minority or Caucasian

☐ Asian Indian ☐ Pacific Asian ☐ Native American ☐ Other _____

Sex of Business Owner ☐ N/A (Not independently owned) ☐ Male ☐ Female

Indicate applicable licenses and/or certifications possessed:

Contractor's State Licensing Board No.	PUC License Number CAL-T-	<input type="checkbox"/> N/A Required Licenses/Certifications (If applicable)
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Signature		Date Signed
Printed/Typed Name		Title

Public Records Information

The above information is required for statistical and/or bidding purposes. Completion of this form is mandatory. This information will be made public upon award of the contract and will be supplied to CDHS' Contract Management Unit, Department of General Services and possibly other public agencies. To access your contract related records, contact the Contract Management Unit, 1800 3rd Street (Room 455), P.O. Box 942732, Sacramento, CA 94234-7432, telephone number (916) 322-6122.

REQUEST FOR INCLUSION ON MAILING LIST

The California Department of Health Services (CDHS) will continue to provide automatic updates about RFA 07-65211 **only** to prospective Applicants who complete and return this Request for Inclusion on Mailing List form. In order to continue to receive updated information relevant to this RFA, please return this form by 4:00 p.m. on June 22, 2007. However, CDHS will remove from its Mailing List all entities from whom it has not received this completed form by that time and will not add entities to the Mailing List until the Office of Medi-Cal Procurement (OMCP) receives the completed form, or a telephonic request as indicated below.

It is incumbent upon any Applicant who has not submitted the Mandatory Request for Inclusion on Mailing List form by 4:00 p.m. on June 22, 2007, but intends to bid on this contract, to monitor the website at <http://www.dhs.ca.gov/omcp> for any administrative bulletins and/or RFA addenda updates to the RFA. An Applicant may also call (916) 552-8006 to request any administrative bulletins and/or RFA addenda updates to the RFA.

Submit this Request for Inclusion on Mailing List form through one of the following methods:

U.S. Mail:	Hand Delivery or Overnight Express/Courier Service:
Mailing List for RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement PO Box 997413, MS 4200 Sacramento CA 95899-7413	Mailing List for RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk CA Department of Health Services Office of Medi-Cal Procurement 1501 Capitol Ave, Suite 71-3041 Sacramento CA 95814
Fax: Mailing List for RFA 07-65211 Sacramento Dental GMC Lenatte Blouin and Sharon Turk Department of Health Services Office of Medi-Cal Procurement Fax: (916) 440-7369	

Name of Proposer:

Mailing Address (Street address, P.O. Box, City, State, Zip Code):

Contact Name:

Title:

Telephone number:

()

Fax number:

()

MANDATORY LETTER OF INTENT

Purpose	This is a non-binding Letter of Intent whose purpose is to assist CDHS in determining the staffing needs for the application evaluation process and to improve future procurements.
Information requested	CDHS is interested in knowing if your firm intends to submit an application or your reasons for not submitting an application. Completion of this form is mandatory.
Action to take	Indicate your intention to submit an application by checking items 1 or 2 below. Follow the instructions below your selection.

1. ☐ **My firm intends to submit an application.**

- A. Check box number 1 if the above statement reflects your intention.
 B. Complete the bottom portion of this form and return it to CDHS as instructed in the RFA section entitled, "Mandatory Non-Binding Letter of Intent".

2. ☐ **My firm does not intend to submit an application for this project.**

- A. Check box number 2 if the statement in item 2 reflects your intention.
 B. Indicate your reason(s) for not submitting an application by checking any of the following statements that may apply.
- ☐ My firm lacks sufficient staff expertise or personnel resources to meet the requirements.
 - ☐ My firm lacks sufficient experience (i.e., not enough or wrong type).
 - ☐ My firm believes the qualification requirements are too restrictive.
 - ☐ Not enough time was allowed for application preparation.
 - ☐ Too much paperwork is required to prepare an application response.
 - ☐ Other commitments and projects have a greater priority.
 - ☐ My firm did not learn about the contract opportunity soon enough.
 - ☐ My firm does not provide the full range of services that CDHS is seeking.
 - ☐ My firm is only interested in becoming a subcontractor, consultant or supplier.
 - ☐ My firm cannot meet the DVBE requirements - we do not wish to subcontract any work out.
 - ☐ Too much effort and/or paper work is required to meet California DVBE requirements.
 - ☐ Insufficient time was allowed for DVBE compliance.
 - ☐ Other reason: _____

- C. Complete the bottom portion of this form and return it to CDHS as instructed in the RFA section entitled, "Mandatory Non-Binding Letter of Intent".

Name of Firm: _____

Printed Name/Title: _____

Address: _____

Phone/Fax/E-Mail Address: _____

Signature: _____

Date: _____

**CURRENT/PROPOSED DENTAL PROVIDER NETWORK
(Sacramento County)**

Please report all figures as whole numbers.

1. Number of primary care dentists located in Sacramento County. _____
2. Number of dental specialists located in Sacramento County. _____
3. Number of prepaid patients located in Sacramento County. _____
4. Ratio of primary care dentists to prepaid patient population: _____
5. Ratio of dental specialists to prepaid patient population: _____

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 5/06)

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, state, and local (including school districts), are not required to submit this form.								
2	PAYEE'S LEGAL BUSINESS NAME (Type or Print) <hr/> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)</td> <td style="width: 50%; border: none;">E-MAIL ADDRESS</td> </tr> <tr> <td style="border: none;">MAILING ADDRESS</td> <td style="border: none;">BUSINESS ADDRESS</td> </tr> <tr> <td style="border: none;">CITY, STATE, ZIP CODE</td> <td style="border: none;">CITY, STATE, ZIP CODE</td> </tr> </table>			SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS	MAILING ADDRESS	BUSINESS ADDRESS	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS								
MAILING ADDRESS	BUSINESS ADDRESS								
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE								
3 PAYEE ENTITY TYPE CHECK ONE BOX ONLY	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): - 		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.						
	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; vertical-align: top;"> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </td> <td style="width: 30%; vertical-align: top;"> CORPORATION: <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS </td> <td style="width: 40%; vertical-align: top;"> <input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: - - </td> </tr> </table>		<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST	CORPORATION: <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: - - 				
<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST	CORPORATION: <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: - - 							
	(SSN required by authority of California Revenue and Tax Code Section 18646)								
4 PAYEE RESIDENCY TYPE	<input type="checkbox"/> California resident—qualified to do business in California or maintains a permanent place of business in California. <input type="checkbox"/> California nonresident (see reverse side)—Payments to nonresidents for services may be subject to State income tax withholding. <div style="margin-left: 40px;"> <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached. </div>								
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.								
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)		TITLE						
	SIGNATURE	DATE	TELEPHONE ()						
6	Please return completed form to: Department/Office: <u>California Department of Health Services</u> Unit/Section: _____ Mailing Address: _____ City/State/ZIP: _____ Telephone: () _____ FAX: () _____ E-Mail Address: _____								

PAYEE DATA RECORD

STD. 204 (Rev. 5/06) (Page 2)

1	<p>Requirement to Complete Payee Data Record, STD. 204</p> <p>A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies.</p> <p>Payees who do not wish to complete the STD. 204 may elect to not do business with the State. If the payee does not complete the STD. 204 and the required payee data is not otherwise provided, payment may be reduced for federal backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.</p>						
2	<p>Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. The mailing address should be the address at which the payee chooses to receive correspondence. Do not enter payment address or lock box information here.</p>						
3	<p>Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State provide their Taxpayer Identification Number (TIN). The TIN is required by the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a).</p> <p>The TIN for individuals and sole proprietorships is the Social Security Number (SSN). Only partnerships, estates, trusts, and corporations will enter their Federal Employer Identification Number (FEIN).</p>						
4	<p><u>Are you a California resident or nonresident?</u></p> <p>A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California.</p> <p>A partnership is considered a resident partnership if it has a permanent place of business in California. An estate is a resident if the decedent was a California resident at time of death. A trust is a resident if at least one trustee is a California resident.</p> <p>For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.</p> <p>Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are \$1,500 or less for the calendar year.</p> <p>For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below:</p> <table border="0"> <tr> <td>Withholding Services and Compliance Section:</td> <td>1-888-792-4900</td> <td>E-mail address: wscs.gen@ftb.ca.gov</td> </tr> <tr> <td>For hearing impaired with TDD, call:</td> <td>1-800-822-6268</td> <td>Website: www.ftb.ca.gov</td> </tr> </table>	Withholding Services and Compliance Section:	1-888-792-4900	E-mail address: wscs.gen@ftb.ca.gov	For hearing impaired with TDD, call:	1-800-822-6268	Website: www.ftb.ca.gov
Withholding Services and Compliance Section:	1-888-792-4900	E-mail address: wscs.gen@ftb.ca.gov					
For hearing impaired with TDD, call:	1-800-822-6268	Website: www.ftb.ca.gov					
5	<p>Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.</p>						
6	<p>This section must be completed by the State agency requesting the STD. 204.</p>						
<p>Privacy Statement</p> <p>Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.</p> <p>It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and State law imposes noncompliance penalties of up to \$20,000.</p> <p>You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the State agency(ies) with which you transact that business.</p> <p>All questions should be referred to the requesting State agency listed on the bottom front of this form.</p>							

BENEFICIARY NON-DISCRIMINATION CERTIFICATION

I, the official named below, certify under penalty of perjury that the applicant is willing and able to enroll members regardless of their race, creed, color, religion, age, sex, national origin, sexual orientation, marital status or ancestry; and without reference to preexisting medical conditions other than those specific conditions to be excluded from coverage under the terms of any contract to be negotiated as a result of this application.

Signature	_____	Date	_____
Printed Name	_____	Title	_____

Attestation

I, the official named below, certify under penalty of perjury, that the applicant is willing and will be able to provide all services required to all areas of the Sacramento County, prior to the execution of any contract.

Signature	_____	Date	_____
Printed Name	_____	Title	_____

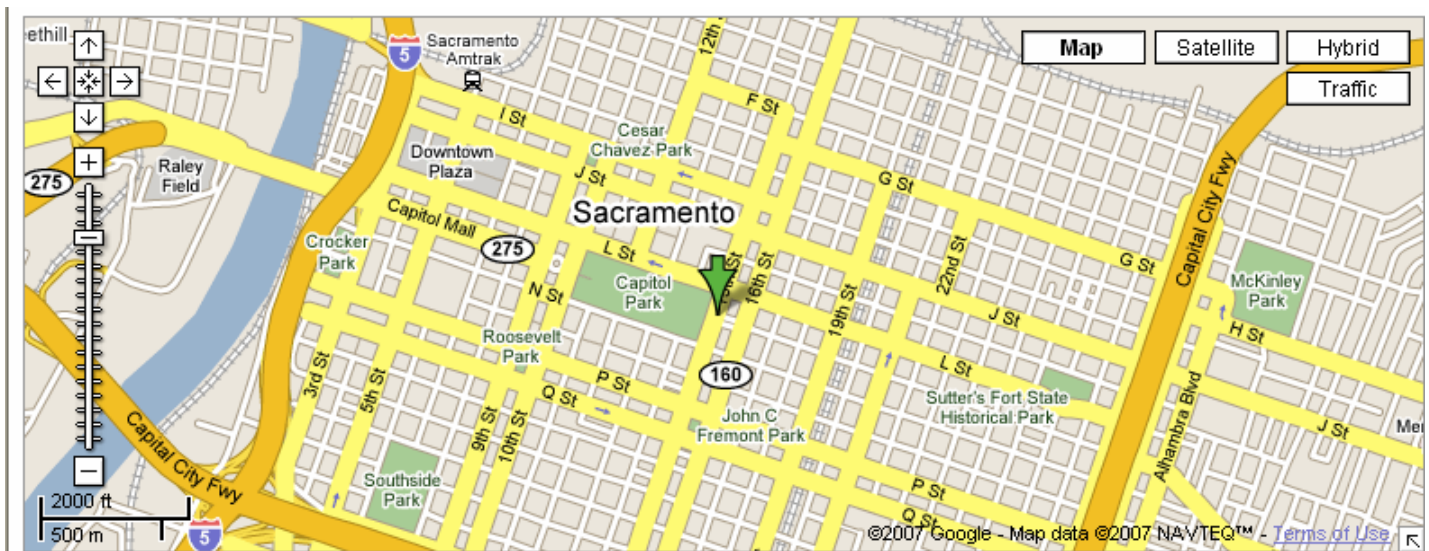
OFFICE OF MEDI-CAL LOCATION MAP

DRIVING DIRECTIONS TO THE OFFICE OF MEDI-CAL PROCUREMENT

Appendix 1

Driving & Parking Instructions to the Department of Health Services

Office of Medi-Cal Procurement
1501 Capitol Ave, Suite 71-3041
Sacramento, CA 95814



From the West: Take Capital City Freeway/US 50 East. Exit 15th Street/CA-160 and merge onto “X” street. Turn left onto 16th Street. Turn left onto Capitol Avenue and arrive at 1501 Capitol Ave. The building is on the NW corner of Capitol Avenue and 16th Street.

From the East: Take US 50 West/ Capital City Freeway. Exit 16th St/CA-160. Turn right onto 16th Street/CA-160. Turn left onto Capitol Avenue and arrive at 1501 Capitol Ave. The building is on the NW corner of Capitol Avenue and 16th street.

From the North (Sacramento Airport): Take I-5 South. Exit “J” Street; proceed on “J” Street. Turn right onto 15th Street/ CA-160. Turn left onto Capitol Avenue. Go to stop light, make left onto 16th street. Make left at Capitol Avenue, arrive at 1501 Capitol Avenue.

From the South: Take I-5 North. Exit “J” Street; turn slight right onto “J” Street. Turn right onto 15th Street/ CA-160. Turn left onto Capitol Avenue. Go to stop light, make left onto 16th street. Make left at Capitol Avenue, arrive at 1501 Capitol Avenue.

Parking is available in garages in the surrounding area.

Appendix 2

Glossary

As used in this Application, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this application:

Accessibility - means a Member's ability to obtain dental care. Accessibility to dental care is determined by such components as the availability of dental services and their acceptability to the patient, the location of dental facilities, transportation and hours of operation.

Affiliate - is defined by CC R, Title 22, § 53102 as an organization or person that, directly or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with, a plan and that provides services to or received services from a plan'.

Applicant - means the Knox-Keene licensed plan.

Beneficiary - means an Eligible Beneficiary, as defined below.

Billing Provider Number - means the number assigned by Denti-Cal to a billing dental provider.

Capitation - means the method of payment in which the Applicant would be paid by the State or the sub-applicant would be paid by the Applicant a fixed amount for a Member over a given period regardless of the actual number or nature of services delivered.

California Children Services (CCS) Program - means a public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41510 et seq.

Child Health and Disability Prevention (CHDP) Program Service - means those preventive health care services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et seq., and Title 17, CCR, Sections 6800 et seq. CHDP is Medi-Cal's implementation of the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Children with Special Health Care Needs (CSHCN) - means, children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment and coordination of care for CSHCN shall comply with the requirements of Title 42 CFR Sections 438.208 (b) (3) and (b)(4) and 438.208 (c)(2), (c)(3), and (c)(4).

CMAC - means the California Medical Assistance Commission.

Confidential Information - means specific facts or documents identified as "confidential" by law, regulation or application language.

Contract - means a binding written agreement, which has been negotiated between the CMAC and Applicant at a future date.

Calendar Year - means a period of time commencing January 1 and concluding on December 31.

Covered Services - means those services as defined in W & I Code 14132(h), in Title 22, CCR, Section 51059 and set forth in Title 22, CCR, Section 51307. The frequency limitations identified may be exceeded based on dental necessity and appropriateness of care, but in no case shall the frequency limitations be more restrictive.

Credentialing - means the recognition of professional or technical competence. The process involved shall include registration, certification, and professional licensure.

Dentally Necessary - means services or supplies which meet the following tests:

- a) They are appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;
- b) They are provided for the diagnosis or direct care and treatment of the dental condition;
- c) They meet the standards of good dental practice within the dental community in the service area;
- d) They are not primarily for the convenience of the plan Member or a plan provider; and
- e) They are the most appropriate level or supply of service that can safely be provided.

Dental Record - means written documentary evidence of all diagnosis and treatments rendered to plan Members. Also known as dental chart.

Dental Specialist – means any dentist(s) whose practice is directed toward highly specialized dental procedures where certification is either required or encouraged by the dental community. Generally such dentist would derive their patients from a referring primary care dentist and would not maintain an on-going relationship with the patient beyond the course of treatment required by the referral.

CDHS - means the California Department of Health Services, the single State agency responsible for administration of the Medi-Cal Program, Children's Medical Services Program, California Children Services, Genetically Handicapped Persons Program, Child Health and Disability Prevention Program, and other health related programs.

DHHS - means the Department of Health and Human Services, the federal agency responsible for management of the Medicaid program.

Director - means when referenced to the State or CDHS, the Director of the State of California Department of Health Services.

Eligible Beneficiary - means a Medi-Cal beneficiary who is residing in Applicant's Service Area with either a mandatory aid code or a non-mandatory aid code. Those with non-mandatory aid codes are not required to enroll in a managed care plan but may do so voluntarily.

Emergency Dental Condition - means a dental condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in:

- a) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- b) serious impairment to bodily functions, or
- c) serious dysfunction of any bodily organ or part.

Examples of Emergency Dental Conditions may include, but are not limited to, the following:

- d) high risk-to-life or seriously disabling conditions such as cellulitis, oral hemorrhage, and trauma.
- e) low risk-to-life or minimally disabling conditions such as painful low-grade oral infections, near pulpal exposures, or fractured teeth.

Emergency Services - means those covered inpatient and outpatient dental services furnished by a qualified dentist which are needed to treat and/or stabilize an Emergency Dental Condition.

Encounter - means a single "face-to-face" visit or dental related service rendered by a provider to an Eligible Beneficiary enrolled in the dental plan on the date of service. It includes, but is not limited to, all services for which Applicant incurred any financial liability.

Encounter Data Record - means a file of an Encounter rendered to a plan Member by a dental provider.

Enrollment - means the process by which an Eligible Beneficiary becomes a Member of Applicant's plan.

Facility - means any premise that is owned, leased, used or operated directly or indirectly by or for Applicant or its Affiliates for purposes related to this Application or maintained by a provider to provide services on behalf of Applicant.

Federal Financial Participation (FFP) - means federal expenditures provided to match proper State expenditures made under approved state Medicaid plans.

Fee-For-Service (FFS) - means a method of reimbursement-based payment for services rendered to a Member.

Financial Statements - means prepared financial reports of the Applicant including balance sheets, income statements, statements of cash flows or uses of cash statement, retained earning statement (statement of equity), the auditor's opinion letter, and any accompanying notes or statements. All records should have been prepared in accordance with generally accepted accounting principles whether audited or unaudited.

Fiscal Year (FY) - means a period of time, generally twelve months, commencing on a date established by a Contract. The State fiscal year is July 1 through June 30; the federal fiscal year is October 1 through September 30.

Geographic Managed Care (GMC) Program - means the GMC Program authorized by Section 14089 et seq., of the W&I Code.

Grievance - means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Member or provider on behalf of a Member.

Health Plan Employer Data and Information Set (HEDIS) - means a set of performance measures designed to standardize the way health and dental plans report data to employers. HEDIS currently measures five major areas of health and/or dental plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health and/or dental plan management.

Knox-Keene Health Care Service Plan Act - means the law which regulates health maintenance organizations and specialized health care (dental) plans and is administered by the Department of Managed Health Care commencing with Section 1340, Health & Safety Code.

Marketing - means any activity or communication conducted on behalf of Applicant where information regarding the services offered by the Applicant is disseminated in order to persuade Eligible Beneficiaries to enroll or to secure the endorsement of any individual or organization on behalf of the Applicant. Marketing also includes any activity or communication that reasonably may be interpreted as intended to influence an Eligible Beneficiary to not enroll in, or disenroll from, another dental plan.

Marketing Representative - means a person who is engaged in marketing activities on behalf of Applicant either through direct employment by Applicant or through a Marketing organization.

Medicaid - means the federal program, run and partially funded by individual states to provide medical and dental benefits to certain low-income people. The state, under broad federal guidelines established by the Health Care Financing Administration (HCFA), determines what benefits are covered, who is eligible and how much providers will be paid.

Medical Support Services - means those services that directly support the delivery of dental procedures which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not necessarily limited to sedation, general anesthesia, utilization of outpatient or inpatient surgical facilities, laboratory, prescription drugs, pre-admission physical exams and medical transportation services.

Medically Necessary - means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, to ensure the ability to achieve age appropriate growth and development, and to ensure the ability to attain, maintain, or regain functional capacity.

When determining the medical necessity of health care services for a Member under the age of 21, the term “medically necessary” is expanded to include all services necessary to correct or ameliorate defects, physical and mental illnesses and conditions discovered by a health care practitioner operating within the scope of his or her practice, but only to the extent that the services are medical in nature and are not requested solely for the convenience of the Member, family, physician, or another service provider. These services must be provided to Members under the age of 21 regardless of whether the service is available to Medi-Cal beneficiaries over the age of 21 under the Medi-Cal program.

Member - means any Eligible Beneficiary who could enroll in Applicant's plan and would receive services as a result of their enrollment.

National Committee for Quality Assurance (NCQA) - means the non-profit organization created to improve patient care quality and dental plan performance in partnership with managed care plans, purchasers, consumers and the public sector.

Other Health Coverage (OHC) - means coverage for dental related services or entitlements for which an Eligible Beneficiary is eligible under any private dental plan, any indemnification insurance program, any other State or federal dental care program, or under other contractual or legal entitlement.

Peer Review - means a review by other members of the profession regarding the quality of care provided a patient, including documentation of care (dental audit), diagnostic steps used, conclusions reached, treatment rendered, appropriateness of utilization (utilization review), and reasonableness of charges claims. The evaluation covers how well all dental personnel perform services and how appropriate the services are to meet the patients' needs.

Primary Dental Care - means a basic level of dental care usually rendered by, and considered being in the scope of practice of general dentists and, in the case of children and adolescents, by pediatric dentists. Primary Dental Care emphasizes an individual's general dental needs as distinguished from specialty dental needs and typically involves ongoing, continuous care, as opposed to episodic or fragmented care.

Primary Care Dentist (PCD) - means a dentist licensed by and in good standing with the California Board of Dental Examiners, who is enrolled in the Medi-Cal dental program (Denti-Cal) and is responsible for supervising, coordinating, and providing initial and Primary Dental Care to Members; for initiating referrals and for maintaining the continuity of care for the Member.

Quality Assurance (QA) - means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both dental services and administrative and support services.

Quality Improvement (QI) - means the result of an effective QA program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services to Members through quality of care studies and other health related activities.

Quality Improvement Plan (QIP) - means systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and established by Contract language. The QIP consists of processes which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis towards an identified, targeted outcome measurement.

Quality of Care - means the degree to which dental services for individuals and populations increase the likelihood of desired dental outcomes and are consistent with current professional knowledge.

Service Area - means Sacramento County.

Service Location - means any location at which it is intended a Member would obtain any dental Covered Service to be provided by Applicant.

Service Site - means the location designated by Applicant at which Members receive Primary Dental Care services.

State - means the State of California.

Sub-application - means a written agreement entered into by Applicant with any of the following:

- a) A provider of dental services that would agree to furnish Covered Services to Members;
- b) A Marketing organization; and
- c) Any other organization or person(s) that agree(s) to perform any administrative function or service for the Applicant which would be used to meet the requirements of the RFA.

Third Party Liability - means the responsibility of an individual or entity, other than Applicant or the Member, for the payment of all or part of the costs of dental services incurred because of illness, trauma, disease, or disability sustained by a Member. This liability may result from a health insurance policy, or other contractual agreement, or legal obligation, excluding tort liability.

Utilization - means the rate patterns of service usage or types of service occurring within a specified time.

Utilization Review - means the process of evaluating the necessity, appropriateness, and efficiency of the use of dental services and procedures.

Exhibit A
Budget Detail and Payment Provisions

1. Fiscal Provisions

- A. **Name of Contractor** agrees to reimburse the California Department of Health Services (CDHS) in accordance with California Budget Act, Provision #5, Chapter 162, Statutes of 1997. The total amount reimbursable for Fiscal Year **2007-2008** shall not exceed **\$20,000**. Any requirement of performance by the CDHS and **Name of Contractor** for the period subsequent to June 30, 2005 shall be dependent upon the availability of future appropriations by the Legislature for the purpose of this Agreement. If future appropriations are made, the maximum amount reimbursable for Fiscal Year 2007-08 shall not exceed \$175,000, and the total amount reimbursable for the Fiscal Year 2008-09 shall not exceed \$175,000. The maximum amount reimbursable under this Agreement shall not exceed \$370,000.
- B. CDHS will provide a quarterly invoice to **Name of Contractor**, and **Name of Contractor** will remit payment within 60 days of receipt of such invoice.
- C. Amount to be remitted shall be **Name of Contractor** share of all costs of administrative and regulatory oversight of the Contract to include:
- 1) CDHS direct costs (i.e., salaries, wages, etc.)
 - 2) CDHS indirect costs (i.e., equipment, travel expenses, etc.)
- D. **Name of Contractor** portion of all costs incurred by CDHS to provide administrative and regulatory oversight of contract compliance shall be determined by **Name of Contractor**. participation in the dental managed care program. Participation shall be calculated according to the following formula:

$$\frac{\text{Name of Contractor total enrollment For quarter billed}}{\text{Total GMC enrollment for quarter billed}} \times \text{Name of Contractor share of} = \text{contract oversight costs (participation in the program)}$$

For Example:

Total program quarterly enrollment:	100,000
Contractor total quarterly enrollment	10,000
Contractor participation:	10%
Total quarterly costs of contract oversight	\$100,000
Contractor quarterly billing (10% participation)	\$ 10,000

Exhibit B
Additional Provisions

1. This Agreement constitutes the entire contract between the parties. Any condition provision, agreement or understanding not stated in this Agreement shall not affect any rights, duties or privileges in connection with this Agreement.
2. Should either party during the term of this Agreement desire a change in this Agreement, such change(s) shall be proposed in writing to the other party. The other party shall accept or reject the change(s) in writing within thirty (30) days of receipt of request.
3. The contracting parties shall comply with the provisions of Section 14100.2 of the Welfare and Institutions Code and Title 42CFR, Section 431.300 to ensure that all information concerning applicants and recipients is kept confidential.
4. This Agreement shall be subject to the examination and audit of the State Auditor for a period of three years after final payment under this Agreement.
5. No covenant, condition, duty, obligation, or undertaking continued or made a part of this Agreement shall be waived except by written Agreement. Amendment executed by the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and until performance or satisfaction of all covenants, conditions, duties, obligations, or undertakings is complete, the other party shall have the right to invoke any remedy available under this Agreement, or under law, notwithstanding such forbearance or indulgence.
6. **Termination**

Termination of this Agreement either by its term or by cause, shall terminate without separate notice, this Administrative Services Agreement.